DELIVERED ORDER FORM

ORDER #_____

FAX TO: 216-378-9116
PHONE: 216-378-9107
PHONE: 877-478-9106
www.CheckpointSurgical.com
Submit to: orders@checkpointsurgical.com

Purchase Order #: _____
Order Date: _____
Delivery Date Requested: _____

Order Placed By: _____ ☐ **Check for new account**

For NERVE WRAP: fax & email required Email Address:_____

Phone #: (_____) _____ Fax #: (_____) _____

Hospital / Physician: _____

Ship to Address: _____

City: _____ State: _____ Zip Code: _____

Bill to Address (if Same leave blank): _____

City: _____ State: _____ Zip Code: _____

Add Product Information Sticker or write in information below:

Product #	Description	Lot #	Price	QTY	Total
			Sales Tax:		_____
			Shipping & Handling:		_____
			Total:		

For Credit Card Orders:

Name of Card Holder: _____

Type: *VISA* *MC* Expiration Date: _____/_____ Security Code: _____

Card Number: _____

AUTHORIZING SIGNATURE: _____

Delivered By:_____
Rep Signature **Print Name** **Date**

Received By:_____
Customer Signature **Print Name** **Date**